EXHIBIT 1
DATE 3-4-09
HB 568

Testimony of the Montana Professional Assistance Program, Inc. regarding HB-568 before the Montana House of Representatives Committee on Business and Labor given on March 4, 2009:

Members of the Committee:

First of all, the bill proposes that a diversion program for licensees under the aegis of the boards of medicine and dentistry be established and administered for *impaired* licensees. Impairment is a fairly nebulous descriptive term, and it is very difficult to prove. This approach increases the likelihood of promoting an adversarial approach to solving the problem of affected practitioners with human health concerns that may, left untreated, compromise the safety of patients. This adversarial approach to the problem promotes increased litigation costs, increases administration costs, and threatens to drive the problem underground.

For over twenty years, the Montana Professional Assistance Program, Inc. has effectively served the needs of distressed physicians and dentists with conditions that left untreated would compromise their ability to safely practice. Our overall rate of successful rehabilitation is 88.5%. Current statutes and rules effectively provide for the early detection, prevention, and referral of licensees suspected of possible impairment to the designated rehabilitation provider (MPAP) in lieu of reporting to the respective board. We also are required to report significant non-compliance with aftercare requirements or relapse to the board. This is a carrot and stick approach. Essentially, current statues provide incentive for early detection and referral. The proposed changes contained in HB-568 take away the carrot, and provide disincentive for those affected to seek treatment early in their disease process; thereby leaving only the stick. The proposed bill is a step in the wrong direction, as far as progressively and proactively addressing the problem of impairment in health care professionals, and it threatens to undo in a single stroke the gains that have been hard fought and won in promoting early detection and referral of physicians and dentists with drug and alcohol or other psychiatric disorders over the past twenty-plus years.

Assigning a diversion program manager within the Department of Labor and Industry, under the supervision of a diversion evaluation committee will be perceived by those affected as a detractor to seeking help. Once again, this will drive the problem underground. Affiliating the functions of referral and monitoring with the licensure board will be viewed as punishment for those affected. Developing a private, non-profit corporation at arms length from the boards was considered essential in the early development of the MPAP in order to increase the likelihood of early detection and referral. Essentially, the proposed changes would be perceived to punish chemically dependent and psychiatrically impaired physicians for being sick.

The bill requires review and acceptance or refusal of prospective participants in the diversion program by a diversion evaluation committee. Logistically, this approach shall result in delays in evaluation, treatment and monitoring at critical junctures in the affected practitioners rehabilitation process. We will lose people to their disease as a result of these delays. When a distressed physician or dentist is ready to receive help, time is of the essence. These noted delays in accepting a prospective participant into the monitoring program were part of the reason that the California Diversion Program failed. In that instance, private providers with no formal relationship with the board or the Diversion Program stepped in to fill a void between

intervention and eventual state-sanctioned monitoring in the Diversion Program. There was no continuity of care, and delays for acceptance into monitoring occurred in some instances for several years. In Montana, we cannot afford to lose that many otherwise qualified and competent providers. Ultimately, patient safety will be diminished if this bill is allowed to pass.

The language in HB-568 regarding the diversion evaluation committee determining whether a participant may safely continue or resume practice represents yet another obstacle to rehabilitation and reentry of properly evaluated and treated licensees. The rigorous standards for evaluation, treatment, and monitoring within the existing protocols for the MPAP help to assure that affected practitioners are safe to resume practice. Adherence to these protocols helps to assure continued safety to practice. Creating a bureaucracy that is unresponsive to the real time needs of affected practitioners will, once again, detract from our ability to effectively serve the needs of all stakeholders.

In Section 3 of the proposed bill, participation in the diversion program would be limited to licensees only. This provision summarily would prevent applicants from out-of-state with a history of evaluation, treatment, or monitoring for a human health concern from receiving favorable consideration for licensure in Montana. The people of Montana, particularly in underserved areas of the State, would suffer as a result of this provision, when otherwise well qualified and competent providers were discouraged or prevented from seeking licensure here.

The following tables are reported from database files of the Montana Professional Assistance Program, Inc.:

Out-of-State Applicants for Montana Licensure with History of Impairment by Disposition by Year **TABLE ONE**

	2009	2008	2007	2006	2005	2004	TOTAL
License Granted – Monitoring		2	1	1	3	5	12
Withdrew Application	1	3	3		3	2	12
Inquiry Only		1	2	4	3	1	11
Unrestricted License Granted		2	1	3	1	1	8
License Denied				1		1	2
TOTAL	1	8	7	9	10	10	45

Out-of-State Physician Applicants with History of Impairment Granted Montana Licensure with MPAP Monitoring (Total and Active) by Medical Society **TABLE TWO**

Medical Society	Total Physician Participants	Active Physician Participants	
1	-	-	Kalispell/Whitefish
2	3	1	CutBank/Browning

3	3	1	Havre/Chinook//Big Sandy
4	1	1	Glasgow/Culbertson/Wolf Point/Plentywood
5	3	1	Miles City/Baker/Lame Deer
6	4	1	Billings
7	-	-	Lewistown
8	2	1	Great Falls
9	2	-	Helena
10	1	-	Livingston
11	1	1	Bozeman
12	1	-	Butte/Dillon/Twin Bridges/Ennis
13	2	-	Anaconda/Warm Springs/Phillipsburg
14	3	2	Missoula
15	2	1	Plains/Thompson Falls/Ronan
16	3	1	Sidney/Glendive
	N = 31	N = 11	

Out-of-State Dentist Applicants with History of Impairment Granted Montana Licensure with MPAP Monitoring (Total and Active) by Dental Society **TABLE THREE**

Dental Society	Total Dentist Participants	Active Dentist Participants	
6	2	2	Bozeman/Livingston
7	1	1	Havre
9	1	-	Billings
	N = 4	N = 3	

Table One provides summary data on all license applicants or inquiries for medicine or dentistry received on referral by the MPAP with a history of evaluation, treatment, or monitoring for the previous five years. Of the 45 total applicants, twelve (27%) were recommended for licensure subject to monitoring compliance with MPAP. An equal number withdrew their applications in lieu of possible denial; while eleven (24%) elected to not pursue application further. Eight of the total number of applicants with a history of impairment (18%) were granted full, unrestricted licensure without further monitoring recommended. Finally, two of the 45 applicants formally were denied licensure. What this table demonstrates is that the review and vetting process for applicants for medical or dental licensure from other jurisdictions with a history of impairment is fairly rigorous in the State of Montana, utilizing existing protocols with consultation by the MPAP.

Tables Two and Three demonstrate that placement of physician and dentist applicants following licensure is spread throughout the State. Currently, eleven of 42 active physician participants are serving patients in 14 of 16 Medical Societies throughout Montana. These eleven current

participants initially were applicants from out-of-state with a history of impairment who were granted licensure and continue functioning well as assured by their continued monitoring compliance with MPAP. Dentists licensed in Montana following history of evaluation, treatment, and monitoring in another state are proportionately fewer in comparison to the medical participant caseload, yet no less significant in their contribution to serving the dentistry needs of the people of the State of Montana.

In the event that HB-568 should pass, applicants from out-of-state would be precluded from applying for participation in the Montana Professional Assistance Program. We no longer would be able to recruit and retain otherwise qualified and competent health care providers with a history of impairment from out-of-state.

In proposed Section 5, sub (3), participation in the program has *never* been an effective defense to any disciplinary action taken by the board. This represents clear misunderstanding of the current process of promoting patient safety while encouraging rehabilitation of affected practitioners. The language is draconian.

Providing confidential patient care information, privileged peer review records, and federally protected drug and alcohol treatment records to the licensure board absent a compelling State interest (e.g. threat to public safety) is contraindicated clinically and may be a violation of both state statutes and federal confidentiality regulations (42 CFR, Part 2).

Since program inception, confidentiality of referral and participant evaluation, treatment, and monitoring records has been a cornerstone of the professional assistance program. Section 6 nullifies the "safe harbor" provisions of existing statute, provides disincentive to early detection and referral, and threatens to punish physicians and dentists for having human health concerns. The proposed review of all files of program participants by the board is a clear violation of federal confidentiality regulations, peer review protections in statue, and patient confidentiality laws. Furthermore, 64% of current participant caseload is unknown to the licensure board. Should HB-568 pass, monitoring of these participants would be discontinued under the existing program, and their continued stability in practice could not be assured. These participants would be given the option of continuing voluntarily with the diversion program under the board, or they could opt out of continued monitoring without recourse.

In Section 8, sub (5) and sub (6) seem to suggest that the functions of the diversion program would be bifurcated into two separate entities, one for licensees with drug and alcohol problems – the other with other mental health disorders. Current caseload suggests that this distinction is unnecessary and contraindicated, since 75% of current participants in the MPAP carry more that one diagnosis, while 87% of current chemically dependent participants have a secondary co-morbid non-substance use related diagnosis on Axis I.

Section 9 also refers to "programs" (in the plural sense). Once again, having more than a single designated provider for rehabilitation of affected licensees diminishes the effectiveness of the program. It provides a forum in which the distressed physician can shop around for an easier, softer way than having to accept rigorous proven standards for evaluation, treatment, and

monitoring, thereby protracting the disease process and potentially compromising patient safety, while avoiding the absolute necessity of accepting personal responsibility for getting better.

Section 10 appears to be a reiteration of existing reporting requirements of current statute in medicine, which are different in the proposed Section 14 for dentistry. These distinctions are unclear and will create a loophole through which a prospective participant may argue successfully for adherence to the lesser standard of dentistry.

The bill, if passed, would nearly double the cost of delivering rehabilitation services to licensed physicians and dentists in Montana. Current funding of the MPAP by medicine and dentistry is $177,500 per year. This bill is estimated to increase expenditures by $173,200 for the first year, then ~$140,000 each year thereafter. The bill would create more bureaucracy without increasing the level and quality of service provided. With the loss of caseload numbers due to a large percentage of current MPAP participants opting out of further monitoring, the cost of rehabilitation and monitoring per licensee would increase proportionately, as well. Fee increases in the amount of ~$15.00 per licensee under the aegis of the Boards of Medicine and Dentistry would be necessary.

In summation, this is a BAD BILL. It threatens to undo all of the gains that have been made in early detection and referral of Montana physicians and dentists with conditions of impairment. If passed, the bill shall result in driving the problem underground, thereby exposing the people of the State of Montana to unsafe practitioners due to their inability to seek help for fear of reprisal and discrimination on the basis of disability. The current structure and function of the professional assistance program under contract with the respective licensure boards is effectively serving the needs of all stakeholders. If it isn't broke, don't fix it.

I strongly recommend a vote of DO NOT PASS on HB-568.

Respectfully Submitted,

Michael J. Ramirez, M.S., CRC
Clinical Coordinator
Montana Professional Assistance Program, Inc.
3333 Second Avenue North, Suite #200
Billings, Montana 59101
mpap@montana.net
406-245-4300

TALKING POINTS

- The bill will dismantle confidentiality provision of existing statute, thereby removing incentive for early referral, leaving only the threat of sanction - basically, undoing 20 years worth of hard work in one fell swoop. It will take away the carrot, and leave only the stick.

- The bill will nearly double the cost of administering a program for health professionals, while decreasing its effectiveness. The bill will create an additional layer of bureaucracy, while reducing the likelihood of successful outcomes. Licensure fees for all licensees under Medical Examiners and Dentistry would be raised proportionately.

- The bill will prevent otherwise qualified applicants from out of state with a history of impairment from participating in the monitoring program, thereby preventing them from gaining licensure. 14 of 16 medical societies and 3 of 14 dental societies have received program participants who applied from out-of-state and were granted licensure. These practitioners continue to effectively serve the health care needs of the people of the State of Montana.

- The bill will drive the problem underground - thereby increasing the threat to patient safety, and the increasing the exposure of all stakeholders to negative outcomes. Montana will no longer be considered a "recovery friendly state" for physicians and dentists.

David G. Healow, M.D.
Consultant, American Board of Anesthesiology
Montana Medical License 5042
652 Park Lane
Billings MT 59102-1931
Office 406 252 6674 Cell 406 855 1799

030309
House Business and Labor Committee
2009 Montana Legislature

Re: HB 568

Dear Representatives:

I write in opposition to HB 568 and ask that you vote against passing it out of committee.

By way of disclosure, I serve as Medical Director to the Montana Professional Assistance Program which currently serves the Boards of Medical Examiners and Dentistry in administering the program currently in statute.

Our program has evolved over the 25 years since the original statute. Guided by local and national experience and the medical literature, we have assisted many physicians, dentists and other licensed practitioners in their recovery from illnesses which threatened their health and ability to practice and the public welfare. The statute and resulting rules have evolved over the same period to refine the delivery of services to protect the public and support the distressed practitioner. The proposed changes included in HB 568 will degrade, dismantle and destroy an evolved, evidence based and effective program and replace it with an unproven, bureaucratic, speculative and punitive process that will discard the experience and effectiveness of the current program. The principles of provider assistance that have emerged over the past 25 years are disregarded in the proposed changes and replaced with an unproven administrative model.

The goals of early intervention, effective treatment, relapse prevention, effective reentry and extended monitoring are essential to this type of program. The proposed legislation utilizes a bureaucratic structure which has demonstrated years of experience to be less effective in supporting effective medical and dental provider recovery than the independent model currently in statute. Because HB 568 moves all the functions into government, it will invariably increase costs while reducing the confidentiality essential to any health care process. In my opinion, adoption of this bill will encourage medical and dental providers with diseases of impairment to avoid the voluntary disclosure encouraged under the current system and instead hide their progressive disabilities. This can only hurt the public safety as well as the health of the involved provider.

There is no valid reason for the proposed changes. Our current program has gained and held the confidence of the medical and dental boards as well as the state and local

medical and dental associations, the hospitals and their associations and our participants. To discard this record of success and the vast experience gained and replace the current provider health model with a new unproven mechanism seems to require some valid justification or motivation. I see none from my perspective. I advocate and encourage that you do not support this bill, HB 568.

Thank you for your service.

Sincerely,

David G. Healow, MD
Medical Director
Montana Professional Assistance Program

To whom it may concern,

My name is Richard Moore and I am a family practice physician working up at the Fort Belknap Indian Reservation. I have spent most of my professional career working in public institutions in Montana. Over the last 20 years I have worked as a physician on several reservations, in the Montana State Prison, and at The Butte Community Health Center.

Eleven years ago my wife brought clarity into my life and helped me realize that I had a problem with alcohol. I went off to treatment and upon returning to Montana I enrolled in the Montana Professional Assistance Program. Over the last 11 years I have found MPAP to be very professional institution that has been strict, firm, and fair with me. It has always placed the public safety first. Their rigorous monitoring policies have assisted me in staying sober over these last 11 years. Because of MPAP I have been able to continue serving the citizens of Montana and have a very happy and productive life.

I strongly urge that you not change the structure/function of MPAP. I believe it has served the professional community and general public well.

Sincerely,

Richard Moore, MD

MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.

The Montana Professional Assistance Program, Inc. is a private, non-profit 501(c)(3) corporation created to serve the rehabilitation needs of licensed physicians throughout the State of Montana. Its mission is to provide advocacy, monitoring and support services to health care professionals with conditions of impairment under separate contracts with the Montana Board of Medical Examiners and the Board of Dentistry. Services include community education and outreach, intervention, appropriate referral, reintegration, and aftercare for program participants and referrals.

The MPAP is structured to provide for early diagnosis and intervention, appropriate evaluation and treatment referrals, and meaningful structured rehabilitation for impaired practitioners before they become incompetent, develop serious or fatal physical disorders, and/or endanger the health and welfare of their patients. The philosophy of the program is that illness or impairment is not always synonymous with incompetence.

MPAP has provided professional advocacy and aftercare monitoring services to licensed physicians in Montana since 1986. Over the years, we have been involved in 469 cases of suspected impairment involving medical professionals. This figure includes 368 physicians referred for consultation and/or evaluation, and 166 physicians who subsequently received treatment and were monitored. For Dentistry, 42 dental professionals have been referred; while 25 dentists have been monitored. Presently, the program has a total of 53 active participants, which includes 42 physicians and ten dentists. Rate of successful rehabilitation for all participants since program inception is 88.5%.

It is important to note that physicians must feel free to seek help for mental health problems before they shall do so willingly. A number of factors contribute to a physician's likelihood to seek help. These factors include training and education regarding conditions which may affect their ability to practice, assurance of confidentiality of patient records, dissemination of information regarding pertinent statutes and rules of conduct, and fostering a physician health system which encourages self-referral free from punitive measures. A rehabilitative posture is paramount to assuring an environment in which physicians are free to seek help for personal problems which may impact their ability to practice with reasonable skill and safety.

MPAP supports the position that early identification and intervention is sound public policy with respect to physician health problems.

Currently, physician colleagues and hospital administration represent the largest referral source at 41%, followed by the Medical Board at 27%, while self-referrals have been reported in 21% of total MPAP referrals. Over time, an increase in the frequency of self-referrals and collegial-referrals, with concurrent reduction in frequency of board referrals indicates a positive trend toward a rehabilitative posture. Additionally, ratio of physician referrals and participants who are known to the board vis a vis those who are unknown to the board is yet another indicator of a healthy professional assistance program. Currently, the Board of Medical Examiners officially knows the identity of 57% of all referrals and 36% of all active participants under their auspices. It is our hope that more and more, program participants will voluntarily enter the MPAP, whether by means of self-referral, or at the urging of professional colleagues, family or friends.

Confidentiality is stressed as one of the cornerstones of the program. The MPAP feels that practitioners, colleagues, family and friends are more likely to be successful in convincing an impaired practitioner to seek help voluntarily when there are no harsh punitive overtones, threats of public embarrassment, or threat to the practitioner's ability to continue his or her professional practice.

Notwithstanding the desire of the MPAP to extend confidential help and assistance to impaired practitioners, the program is bound by state statute to report to the professional licensing board a practitioner who is (a) medically incompetent; (b) mentally or physically unable to safely engage in the practice of medicine; and (c) guilty of unprofessional conduct.

In addition, the MPAP reserves the right to report to the licensing board those individuals who (a) have a clearly definable problem and refuse to seek treatment; or (b) those individuals who have received treatment but fail to adhere to the requirements of their aftercare monitoring contract. Administrative rules governing reporting requirements of the Professional Assistance Program recently were adopted in 2006 (*cf ARM 24.156.401 ff*). Peer review privilege protections were extended to MPAP records for physicians during the 2007 Legislature *(cf 37-3-208, MCA)*.